

STATE OF ILLINOIS

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Facility Name & ID Number Imboden Creek Living Center# 0036574 Report Period Beginning: 10/01/03 Ending: 09/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>95</u>	Skilled (SNF)	<u>95</u>	<u>34,770</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>95</u>	TOTALS	<u>95</u>	<u>34,770</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>7,005</u>	<u>18,073</u>	<u>5,123</u>	<u>30,201</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,005</u>	<u>18,073</u>	<u>5,123</u>	<u>30,201</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 86.86%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒NO ☐

I. On what date did you start providing long term care at this location?

Date started 09/08/1990

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 95and days of care provided 5,123Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 09/30/04Fiscal Year: 09/30/04

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning: 10/01/03

Ending: 09/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	206,690	24,563	12,055	243,308		243,308		243,308		1
2	Food Purchase		222,367		222,367	(23,184)	199,183		199,183		2
3	Housekeeping	125,838	28,835		154,673		154,673	288	154,961		3
4	Laundry	35,710	23,287		58,997		58,997		58,997		4
5	Heat and Other Utilities			80,591	80,591		80,591	2,957	83,548		5
6	Maintenance	55,121	14,857	99,938	169,916		169,916	11,372	181,288		6
7	Other (specify):*										7
8	TOTAL General Services	423,359	313,909	192,584	929,852	(23,184)	906,668	14,617	921,285		8
	B. Health Care and Programs										
9	Medical Director			16,800	16,800		16,800		16,800		9
10	Nursing and Medical Records	1,325,885	88,047	10,151	1,424,083		1,424,083		1,424,083		10
10a	Therapy										10a
11	Activities	52,404	5,426	2,752	60,582		60,582		60,582		11
12	Social Services	26,417		1,482	27,899		27,899		27,899		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* Dental Consultant			600	600		600		600		15
16	TOTAL Health Care and Programs	1,404,706	93,473	31,785	1,529,964		1,529,964		1,529,964		16
	C. General Administration										
17	Administrative	123,953			123,953		123,953	45,340	169,293		17
18	Directors Fees										18
19	Professional Services			12,900	12,900		12,900	3,853	16,753		19
20	Dues, Fees, Subscriptions & Promotions			19,314	19,314		19,314	786	20,100		20
21	Clerical & General Office Expenses	26,966	17,189	22,227	66,382		66,382	63,709	130,091		21
22	Employee Benefits & Payroll Taxes			253,732	253,732	23,184	276,916	8,693	285,609		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,508	4,508		4,508		4,508		24
25	Other Admin. Staff Transportation			1,547	1,547		1,547	(4,336)	(2,789)		25
26	Insurance-Prop.Liab.Malpractice			82,784	82,784		82,784	3,021	85,805		26
27	Other (specify):*			23,523	23,523		23,523	(23,523)			27
28	TOTAL General Administration	150,919	17,189	420,535	588,643	23,184	611,827	97,543	709,370		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,978,984	424,571	644,904	3,048,459		3,048,459	112,160	3,160,619		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number **Imboden Creek Living Center**

#0036574

Report Period Beginning:

10/01/03

Ending:

09/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			42,629	42,629		42,629	93,269	135,898			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							142,077	142,077			32
33	Real Estate Taxes			84,000	84,000		84,000	5,201	89,201			33
34	Rent-Facility & Grounds			498,000	498,000		498,000	(498,000)				34
35	Rent-Equipment & Vehicles			2,055	2,055		2,055		2,055			35
36	Other (specify):*											36
37	TOTAL Ownership			626,684	626,684		626,684	(257,453)	369,231			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		171,148	320,064	491,212		491,212		491,212			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,156	52,156		52,156		52,156			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		171,148	372,220	543,368		543,368		543,368			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,978,984	595,719	1,643,808	4,218,511		4,218,511	(145,293)	4,073,218			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **Imboden Creek Living Center**# **0036574**Report Period Beginning: **10/01/03**Ending: **09/30/04****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(11,849)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	750	30		9
10	Interest and Other Investment Income	(12,514)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(451)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(35)	27		18
19	Entertainment	(44)	27		19
20	Contributions	(4,645)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,174)	27		24
25	Fund Raising, Advertising and Promotional	(12,621)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Page 5A	(2,009)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (47,592)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(287,429)		34
35	Other- Attach Schedule Page 5B	189,728		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (97,701)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (145,293)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Imboden Creek Living Center

ID# 0036574

Report Period Beginning: 10/01/03

Ending: 09/30/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	IPAC Dues	\$ (456)	20	1
2	Gifts	(1,553)	27	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,009)		49

Summary A

09/30/04

09/30/04

[illegible]

Summary B

09/30/04

09/30/04

[illegible]

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning:

10/01/03

Ending:

09/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John & Martha Brinkoetter	100			Imboden Gardens	Decatur	Assisted Living

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 512,184	John & Martha Brinkoetter	100.00%	\$	\$ (512,184)	1
2	V	30 Depreciation		John & Martha Brinkoetter	100.00%	83,238	83,238	2
3	V	32 Interest		John & Martha Brinkoetter	100.00%	141,517	141,517	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 512,184			\$ 224,755	\$ * (287,429)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/03 Ending: 09/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Brinkeotter	President	Administrative	100.00		40	100.00	Salary	\$ 35,992	17,7	1
2	Martha Brinkoetter	Clerical	Clerical	100.00		40	100.00	Salary	17,271	21,7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 53,263		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Imboden Creek Living Center# 0036574

Report Period Beginning:

10/01/03Ending: 09/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Imboden Creek GardensStreet Address 185 W. Imboden DriveCity / State / Zip Code Decatur, IL 62521Phone Number (217) 233-1425Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3 Wages-Cleaning	Days	38,327	2	\$ 366	\$ 366	30,201	\$ 288	1
2	21 Telephone	Days	38,327	2	6,468		30,201	5,097	2
3	5 Utilities	Days	38,327	2	3,752		30,201	2,957	3
4	6 Supplies-Repairs	Days	38,327	2	2,628		30,201	2,071	4
5	6 Repairs & Maintenance	Days	38,327	2	11,803		30,201	9,301	5
6	17 Management Consultants	Days	38,327	2	11,863		30,201	9,348	6
7	17 Wages-Administrative	Days	38,327	2	45,676	45,676	30,201	35,992	7
8	21 Wages-Clerical	Days	38,327	2	83,517	83,517	30,201	65,810	8
9	19 Accounting Fees	Days	38,327	2	4,890		30,201	3,853	9
10	20 License & Fees	Days	38,327	2	370		30,201	292	10
11	26 Insurance	Days	38,327	2	3,834		30,201	3,021	11
12	33 Real Estate Taxes	Days	38,327	2	6,600		30,201	5,201	12
13	21 Office Supplies	Days	38,327	2	5,241		30,201	4,130	13
14	34 Rent	Days	38,327	2	18,000		30,201	14,184	14
15	30 Depreciation	Days	38,327	2	11,778		30,201	9,281	15
16	32 Interest Expense	Days	38,327	2	16,592		30,201	13,074	16
17	25 Auto Expense	Days	38,327	2	(5,503)		30,201	(4,336)	17
18	20 Dues & Subscriptions	Days	38,327	2	1,205		30,201	950	18
19	22 Miscellaneous Office	Days	38,327	2	661		30,201	521	19
20	22 Payroll Taxes	Days	38,327	2	11,001		30,201	8,669	20
21	22 Employee Insurance	Days	38,327	2	31		30,201	24	21
22									22
23									23
24									24
25	TOTALS				\$ 240,773	\$ 129,559		\$ 189,728	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Union Planters Bank		X	Real Estate Loan	\$17,632.00	04/27/01	\$ 3,302,473	\$ 2,884,300	04/05/09	5.0000	\$ 141,517	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Union Planters Bank		X	Line of Credit		04/01/04	1,000,000	1,000,000	04/01/05	4.7500	13,074	6	
7												7	
8												8	
9	TOTAL Facility Related				\$17,632.00		\$ 4,302,473	\$ 3,884,300			\$ 154,591	9	
	B. Non-Facility Related*												
10				Interest Income							(12,514)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (12,514)	14	
15	TOTALS (line 9+line14)						\$ 4,302,473	\$ 3,884,300			\$ 142,077	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Imboden Creek Living Center**# **0036574** Report Period Beginning: **10/01/03** Ending: **09/30/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2003 report.			\$	67,608 1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	87,588 2
3. Under or (over) accrual (line 2 minus line 1).			\$	20,687 3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	68,514 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	89,201 7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1999	74,093	8	
	2000	77,594	9	
	2001	82,554	10	
	2002	87,936	11	
	2003	88,900	12	
Real Estate Tax Accrual for 2004				
Nursing Home -\$82,710.3 x 1.03638 x 9 / 12 = \$64,290				
Corp Office -allocated-\$6,189.86 x 1.1546 x 9 / 12 x .788 = 4,224				
	13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Imboden Creek Living Center COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0036574

CONTACT PERSON REGARDING THIS REPORT Martha Brinkoetter

TELEPHONE (217) 422-7150 FAX #: (217) 422-9418

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>04-12-27-231-008</u>	<u>L 0001 B 00 South Franklin Estates</u>	\$ <u>82,710.30</u>	\$ <u>82,710.30</u>
2. <u>04-12-27-278-010</u>	<u>00000105 W. Imboden Dr</u>	\$ <u>6,189.86</u>	\$ <u>4,877.50</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>88,900.16</u>	\$ <u>87,587.80</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,960

B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	143,748	1988	\$ 111,846	1
2					2
3	TOTALS	143,748		\$ 111,846	3

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning:

10/01/03

Ending:

09/30/04

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	95		1990	1990	\$ 2,772,947	\$	40	\$ 69,324	\$ 69,324	\$ 974,334	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sewer Improvements		1991	1991	15,000		20	750	750	10,500	9
10	Landscaping		1992	1992	2,460		10			2,460	10
11	Landscaping - Yard Pad		1992	1992	1,000		10			1,000	11
12	Carpeting		1992	1992	584		10			584	12
13	Decorate Activity Room		1992	1992	852		10			852	13
14	Electrical		1993	1993	2,550		10			2,550	14
15	Carpeting		1993	1993	791		10			791	15
16	Carpeting		1993	1993	747		10			747	16
17	Door		1993	1993	657	5	10	5		656	17
18	Rose Garden Fence		1995	1995	2,495	250	10	250		2,225	18
19	Carpeting		1996	1996	1,121	112	10	112		972	19
20	Drive & Parking Lot		1996	1996	2,065	207	10	207		1,721	20
21	Concrete Drive Service Doors		1995	1995	2,100	210	10	210		1,873	21
22	Carpeting		1997	1997	29,333	2,933	10	2,933		20,289	22
23	Landscaping		1998	1998	2,387	239	10	239		1,492	23
24	Carpeting		1999	1999	2,258	226	10	226		1,223	24
25	Curtains		1999	1999	937	94	10	94		445	25
26	Landscaping		2000	2000	877	88	10	88		417	26
27	Carpeting		2000	2000	2,321	232	10	232		1,006	27
28	Carpeting		2000	2000	3,981	398	10	398		1,692	28
29	Baseboards for Bathrooms		2000	2000	720	72	10	72		306	29
30	Shower Room Tile		2000	2000	2,954	295	10	295		1,255	30
31	Baseboards for Bathrooms		2000	2000	466	47	10	47		195	31
32	Floor Covering		2000	2000	1,032	103	10	103		412	32
33	New Roof		2000	2000	51,000	5,100	10	5,100		20,825	33
34	Roof Drains		2000	2000	3,691	369	10	369		1,476	34
35	Deck		2000	2000	2,668	267	10	267		1,067	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Tile Installation	2000	\$ 1,380	\$ 138	10	\$ 138		\$ 586		37
38	Floor Covering	2000	532	53	10	53		213		38
39	Deck & Handrails	2001	27,848	2,785	10	2,785		10,443		39
40	Siding	2000	1,475	148	10	148		591		40
41	Kitchen Floor/Baseboards	2001	8,244	824	10	824		2,610		41
42	Carpeting	2002	1,972		10	155	155	492		42
43	Security System	2002	8,338		8	821	821	2,432		43
44	Outside Door	2002	912		10	72	72	190		44
45	Underground Cable System	2002	9,178		10	723	723	2,371		45
46	Glass Door	2002	1,321		10	104	104	352		46
47	Carpeting	2002	2,732	273	10	273		682		47
48	Dining Room Carpeting	2002	11,734	1,173	10	1,173		2,639		48
49	Fire Alarm System	2002	17,894	1,789	10	1,789		3,578		49
50	Roof	2003	5,250		10	414	414	788		50
51	Sprinklers	2003	5,970	597	10	597		597		51
52	New Wander Guard System	2003	2,044	204	10	204		204		52
53	Step by Step Floors	2004	2,723	23	10	23		23		53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 3,019,541	\$ 19,254		\$ 91,617	\$ 72,363	\$ 1,082,156		70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 409,935	\$ 15,177	\$ 35,876	\$ 20,699	5	\$ 271,665	71
72	Current Year Purchases	37,146	1,163	1,370	207	5	1,426	72
73	Fully Depreciated Assets	235,646				5	235,646	73
74								74
75	TOTALS	\$ 682,727	\$ 16,340	\$ 37,246	\$ 20,906		\$ 508,737	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Staff	1992 Toyota 4 x 4	1996	\$ 10,201	\$	\$ 7,035		5	\$ 10,201	76
77	Staff	2001 Ford F150 Truck	2000	35,174	7,035	7,035		5	29,311	77
78	Staff	2001 Lexus LS430	2000	66,573				5	51,339	78
79										79
80	TOTALS			\$ 111,948	\$ 7,035	\$ 7,035	\$		\$ 90,851	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,926,062	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,629	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 135,898	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 93,269	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,681,744	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Related Party

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 2,055 Description: Ice Machine \$1,575 and Dishwasher \$480

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39,3 & 39,2	hrs	\$	3,027	\$ 149,060	\$ 301	3,027	\$ 149,361	1
2	Licensed Speech and Language Development Therapist	39,3 & 39,2	hrs		69	5,108		69	5,108	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39,3 & 39,2	hrs		3,201	159,102	523	3,201	159,625	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Med Supplies, Lab, IV	39,2					177,118		177,118	13
14	TOTAL			\$	6,297	\$ 313,270	\$ 177,942	6,297	\$ 491,212	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 9,096	\$ 57,921	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	588,946	646,583	3
4	Supply Inventory (priced at <u>Cost</u>)	7,155	7,155	4
5	Short-Term Investments			5
6	Prepaid Insurance	34,048	60,533	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Intercompany</u>	486,761		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,126,006	\$ 772,192	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	204,624	231,596	15
16	Equipment, at Historical Cost	306,453	604,840	16
17	Accumulated Depreciation (book methods)	(318,232)	(507,893)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Deposits</u>)		91,853	22
23	Other(specify): <u>Note Receivable Stockholder</u>		804,653	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 192,845	\$ 1,225,049	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,318,851	\$ 1,997,241	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 188,714	\$ 216,658	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		43,334	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	106,172	135,262	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,290	170,095	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Advance Billing</u>	240,456	332,891	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 599,632	\$ 898,240	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,000,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,000,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 599,632	\$ 1,898,240	46
47	TOTAL EQUITY (page 18, line 24)	\$ 719,219	\$ 99,001	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,318,851	\$ 1,997,241	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 584,507	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 584,507	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	336,805	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(202,093)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 134,712	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 719,219	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,544,065	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,544,065	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	9,453	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,453	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Memorial Income</u>	1,798	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,798	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,555,316	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	929,852	31
32	Health Care	1,529,964	32
33	General Administration	588,643	33
B. Capital Expense			
34	Ownership	626,684	34
C. Ancillary Expense			
35	Special Cost Centers	491,212	35
36	Provider Participation Fee	52,156	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,218,511	40
41	Income before Income Taxes (line 30 minus line 40)**	336,805	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 336,805	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Page 20

Facility Name & ID Number Imboden Creek Living Center

0036574

Report Period Beginning: 10/01/03

Ending:

09/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,948	2,092	\$ 55,239	\$ 26.40	1
2	Assistant Director of Nursing	1,932	2,084	39,004	18.72	2
3	Registered Nurses	5,333	5,437	93,878	17.27	3
4	Licensed Practical Nurses	20,447	21,157	312,789	14.78	4
5	Nurse Aides & Orderlies	76,344	79,434	690,575	8.69	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,195	4,592	45,072	9.82	8
9	Activity Director	2,359	2,464	24,811	10.07	9
10	Activity Assistants	3,346	3,663	27,593	7.53	10
11	Social Service Workers	2,272	2,392	26,417	11.04	11
12	Dietician					12
13	Food Service Supervisor	2,198	2,310	31,784	13.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,639	23,804	174,906	7.35	15
16	Dishwashers					16
17	Maintenance Workers	4,304	4,541	55,121	12.14	17
18	Housekeepers	15,835	16,790	125,838	7.49	18
19	Laundry	4,859	5,148	35,710	6.94	19
20	Administrator	1,997	2,093	106,175	50.73	20
21	Assistant Administrator	701	701	10,994	15.68	21
22	Other Administrative	423	423	6,784	16.04	22
23	Office Manager					23
24	Clerical	2,054	2,093	26,966	12.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	2,084	2,141	20,019	9.35	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Restorative	2,012	2,148	36,515	17.00	32
33	Other(specify) Care Plan	1,988	2,124	32,794	15.44	33
34	TOTAL (lines 1 - 33)	179,270	187,631	\$ 1,978,984 *	\$ 10.55	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	292	\$ 12,055	1,3	35
36	Medical Director	72	16,800	9,3	36
37	Medical Records Consultant	60	3,000	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	600	10,3	39
40	Physical Therapy Consultant	106	6,551	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,482	11,3	44
45	Social Service Consultant	24	1,482	12,3	45
46	Other(specify)			17,1	46
47	Dental Consultant		600	15,3	47
48					48
49	TOTAL (lines 35 - 48)	590	\$ 42,570		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **Imboden Creek Living Center**# **0036574**Report Period Beginning: **10/01/03**Ending: **09/30/04****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%		Description			Description		
Rhonda Falk	Administrator		\$ 106,175	Workers' Compensation Insurance	\$ 43,284		IDPH License Fee	\$ 1,685	
Cindy See	Asst Admin		10,994	Unemployment Compensation Insurance	26,388		Advertising: Employee Recruitment	6,073	
Diane Hunt	Human Resource		6,784	FICA Taxes	156,442		Health Care Worker Background Check (Indicate # of checks performed <u>78</u>)	1,125	
				Employee Health Insurance	28,352		Licenses	983	
				Employee Meals	23,184		IL Health Care Association	5,469	
				Illinois Municipal Retirement Fund (IMRF)*			Internet Subscription	1,760	
				Innoculations	1,630		Dues & Subscriptions	3,461	
				Incentives	5,142				
				Other	1,142				
				Education	45				
							Less: Public Relations Expense	(456)	
							Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 123,953	TOTAL (agree to Schedule V, line 22, col.8)	\$ 285,609		TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,100	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel	1,434	
							Seminar Expense	3,074	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL	\$ 4,508	
C. Professional Services									
Vendor/Payee	Type		Amount						
BKD, LLP	Medicare consultants		\$ 3,700						
BKD, LLP	Medicare cost report fee		4,200						
FR&R Healthcare	Medicare consultants		5,000						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 12,900						

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number **Imboden Creek Living Center**

STATE OF ILLINOIS

0036574

Report Period Beginning:

10/01/03

Ending:

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09/30/04

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Health Care Assoc. \$5,469
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,121 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 52,156
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 23,184 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? .4%
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Imboden Creek Living Center

ID# 0036574

Report Period Beginning: 10/01/03

Ending: 09/30/04

Sch. V Line

ALLOCATION OF INDIRECT COSTS

Amount

Reference

1	Wages-Cleaning	\$ 288	3	1
2	Telephone	5,097	21	2
3	Utilities	2,957	5	3
4	Supplies-Repairs	2,071	6	4
5	Repairs & Maintenance	9,301	6	5
6	Management Consultants	9,348	17	6
7	Wages-Administrative	35,992	17	7
8	Wages-Clerical	65,810	21	8
9	Accounting Fees	3,853	19	9
10	License & Fees	292	20	10
11	Insurance	3,021	26	11
12	Real Estate Taxes	5,201	33	12
13	Office Supplies	4,130	21	13
14	Rent	14,184	34	14
15	Depreciation	9,281	30	15
16	Interest Expense	13,074	32	16
17	Auto Expense	(4,336)	25	17
18	Dues & Subscriptions	950	20	18
19	Miscellaneous Office	521	21	19
20	Payroll Taxes	8,669	22	20
21	Employee Insurance	24	22	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	189,728		49